STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155776	A. BUILDING 00 B. WING	06/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHILL VILLAGE	1001 E SPRINGHILL DRIVE TERRE HAUTE, IN47802

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F0000	This visit was for a Recertification and State Licensure survey. Survey dates: June 6-10, 2011 Facility Number: 012188 Provider Number: 155776 AIM Number: 200958030 Survey Team: Laura Brashear, RN, TC Mary Weyls, RN, Teresa Buske, RN, 6/6- 6/8/2011 Census Bed Type: SNF: 24 SNF/NF: 72 Total: 96 Census Payor Type: Medicare: 24 Medicaid: 49 Other: 23 Total: 96 Sample: 20 Supplemental sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on June 16, 2011 by Bev Faulkner, RN			
F0164 SS=D	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.			

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	Based on observation and record review, the facility failed to ensure privacy during medical treatments for 2 of 4 residents observed receiving either an insulin injection or receiving gastrostomy tube water flushes in a sample of 20 [Residents #43 and #34] Findings include: 1. On 6/7/11 at 4:30 p.m., RN #9 administered an insulin injection to Resident #43. The resident was sitting in the west lounge area, when the nurse raised the resident's blouse and gave the injection into the resident's abdomen. Thirteen residents were present in the lounge area. 2. On 6/7/11 at 5:15 p.m., RN #9 was providing a water flush to Resident #34's gastrostomy tube. The RN did not pull the privacy curtain or shut the resident's door while exposing the resident's abdomen. Resident #34's roommate was in the room. A facility policy and procedure titled "Resident Rights" and dated 1/06, was received from the Administrator on 6/10/11 at 10:15 p.m. The policy indicated the resident had a right to personal privacy which included medical treatments.	F0164	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on or after July 1, 2011. **F164 Personal Privacy/Confidentiality of Records** It is the policy of this provider to provide privacy during medical treatments. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Corrective Action was implemented with RN #9. Social Services met with Resident #43 and #34 to ensure resident had no negative outcomes from having a medical treatment completed without privacy. Resident # 43 and #34 were provided privacy for other medical treatments. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**	06/24/2011

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	3.1-3(p)(2)		Residents that reside at the facility may be affected by alleged deficient practice. Staff members were educated on 6/21/11 regarding Resident privacy. Education completed by Director of Nursing and Executive Director. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** Education on privacy will be given to all employees upon hire and quarterly. Charge Nurses will conduct rounds each shift to monitor for privacy during medical treatments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** CQI tool Dignity and Privacy will be initiated weekly for four weeks and monthly times two months and quarterly there after. DNS/Designee will monitor for compliance.	
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation and record review, the facility failed to ensure safe transfers by mechanical lift for 1 of 1 resident observed for safe use of assistance devices in a sample of 20. [Resident #83] Findings include: On 6/7/11 at 9:50 a.m., CNAs #12 and #13 were observed to transfer Resident #83 from the wheelchair to the bed with the mechanical Hoyer lift. After attaching the sling, the resident was raised several inches above the seat of the wheelchair, waist high to the nursing staff, was positioned perpendicular to the mast and with the base closed, the resident was transferred to the bed. The base was then opened and the resident lowered onto the mattress. The manufacturer's directions, provided by the Administrator on 6/10/11 at 10:15 a.m., included, but was not limited to, "...If transporting over a short distance, ensure the patient is facing attendant and keep patient as low as possible so that her feet rest on the base of the lifter straddling the mast. Lower center of gravity reduces the risk of tipping over." 3.1-45(a)(2)	F0323	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on or after July 1, 2011. F323 **Free of Accident Hazards/Supervision/Devices** It is the policy of this provider to ensure that the resident environment remains as free as accidents, hazards, as is possible; and each resident receives adequate supervision and assistant devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Corrective Action was completed with C.N.A #12 and #13. Demonstration and return demonstration were completed with CNA #12 and #13. Resident #83 was assessed for potential injuries from incorrect usage of the mechanical lift.	06/24/2011

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			Resident #83 was lifted correctly with the lift after demonstration and return demonstration completed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Residents that reside in the facility that require the use of a mechanical lift have the potential to be affected by the alleged deficient practice. Nursing staff will be educated on proper use of the lift upon hire, skills validations will be completed annually for staff using the mechanical lift. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** Nursing staff members have been educated on proper usage of the mechanical lift per manufacture's guidelines on 6-23-11. Education completed by Director of Nursing. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** CQI tool Mechanical Lift Validation	

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			Tool will will be initiated weekly for four weeks and monthly times two months and quarterly thereafter. DNS/Designee to monitor. Charge Nurses will monitor each shift to ensure manufacture's guidelines are followed.	
F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent or less; in that 3 medication errors in an opportunity of 45 were observed which resulted in a 6.6 percent error rate. [Residents #37, #43, and #83.] Findings include: 1. During observation of medication administration on 6/7/11 at 11:20 a.m., RN #10 administered Humalog insulin [rapid acting] 11 units subcutaneous to Resident #83. Resident #83 was taken to the dining room for lunch at 11:45 a.m. Resident #83's clinical record was reviewed on 6/8/11 at 3:30 p.m. A physician's order was noted, dated 3/7/11, for sliding scale Humalog insulin. The resident received 11 units per sliding scale for a blood sugar of 303.	F0332	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on or after 7-1-11. **F 332 Free of Medication Error Rates of 5% or More.** It is the policy of this provider to ensure that it is free of medication error rates of five percent or greater. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All sliding scale insulin orders have been clarified with the attending physician/medical director. Nurses have been educated on proper administration of short acting insulin.	06/24/2011

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			Charge Nurses will monitor daily for compliance. Resident #37, #43, #83 attending physician reviewed medical record and made appropriate changes to insulin coverage. Resident # 37 #43, and #83 were assessed to ensure there was no negative outcome from receiving insulin early. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All Residents that reside that use short acting sliding scale insulin coverage, in the facility; have the potential to be affected by the alleged deficient practice. All short acting insulin orders have been reviewed by facility Medical Director for appropriateness. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** CQI Medication Pass Audit tool will be initiated weekly for four weeks and monthly times two months and quarterly thereafter. DNS/Designee	

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			to monitor.	

2. On 6/7/11 at 11:45 a.m., LPN #7 administered Novolog (Short acting Insulin) 6 units to Resident #43. At 12:15 p.m., the resident had not received lunch and was propelling herself to the dining room. At 12:30 p.m., the resident was receiving her lunch meal.

Resident #43's clinical record was reviewed on 6/10/11 at 10 a.m.

A diagnosis was noted of, but not limited to, Diabetes Mellitus.

A physician's order was noted, with the original date of 6/21/10, with the most recent physician signed rewrite, dated 4/26/11, of Novolog per sliding scale before meals.

3. On 6/7/11 at 4:30 p.m., RN #9 administered Novolog insulin [short acting] 5 units to Resident #37. The resident was not served her meal until 6

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	p.m. Resident #37's clinical record was reviewed on 6/10/11 at 10 a.m. A diagnosis was noted, but not limited to, Diabetes Mellitus. A physician's order was noted, with the original date of 7/8/10, and the most recent physician signed rewrite, dated 4//13/11, of Novolog per sliding scale before meals. A facility policy titled "Medication Administration" indicated "Administrating medications too early or too late is considered a medication error and must be followed by an incident report. Review of the Nursing 2009 Drug Handbook on 6/10/11 at 2 p.m., documentation indicated give Novolog insulin 5 to 10 minutes before start of meal. 3.1-25(b)(9)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to ensure a resident at risk did not reside with a resident with Clostridium Difficile toxin for 1 of 2 residents reviewed with	F0441	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of	06/24/2011

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	Clostridium Difficile in a sample of 20, in that a resident with a gastrostomy tube and an open wound (# 34) was residing with a resident with symptoms of and with a positive culture of Clostridium Difficile (#33). [Resident #34] Findings include: During initial tour with LPN #14 on 6/6/11 which began at 11:15 a.m., the LPN indicated Resident #33 resided in the same room as Resident #34. The LPN indicated Resident #34 had a gastrostomy tube (GT) and an open area on the right outer ankle. At that time, the residents were observed sharing the room. During interview on 6/8/11 at 1:45 p.m., of Resident #33's family member, the family member indicated Resident #33 had Clostridium difficile. Resident #34's clinical record was reviewed on 6/7/11 at 2:50 p.m. A physician's telephone order was noted, dated 3/11/11, indicated "Send to ...hospital ER (emergency room) for G-tube replacement." A care plan identified on 5/25/11, a concern indicating the resident had an open area on the right outer aspect of the		regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on or after 7-1-11. **F 441 Infection Control** It is the policy of this provider to ensure that the environment is safe, sanitary and comfortable to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All staff members have been educated on infection control policy and procedures, and specifically how it relates to Clostridium Difficile (C-Dif). Resident #34 was moved to an alternate room on 6-9-11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All Residents that reside in the facility have the potential to be affected by the alleged deficient	

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	foot near the 5th toe. Resident #33's clinical record was reviewed on 6/10/11 at 11 a.m. A laboratory test was noted, dated as received by the facility on 4/30/11, indicating the resident's stool tested positive for Clostridium difficile toxin. Nurses' notes indicated the following; 4/30/11 at 12 midnight and at 1:30 p.m., the resident was having loose stools. 5/4/11 at 10:15 a.m., "Had loose BM (bowel movement) X (time) 2 this shift.....BM cont (continue) to be foul smelling." 5/10/11 at 5:30 a.m., the resident had three loose stools that shift. 5/11/11 at 1 p.m., the resident had a loose stool that had a foul odor and was "mucousy." 5/12/11 at 12:30 p.m., "loose, mucousy stools [with] foul odor X 1 this shift." 5/14/11 at 4 p.m., antibiotic continues for "C-Dif" (clostridium difficile). 6/1/11 at 2:30 p.m. "cont to have liquid		practice. All Residents with potentially infectious diseases/infections will be discussed with the Interdisciplinary Team and the infection control policy will be followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Residents with Clostridium Difficile (C-Dif) will be co-horted with residents who do not have indwelling tubes, catheters or open wounds. DNS/Designee to monitor. CQI tool Infection Control Review will be initiated weekly for four weeks and monthly times two months and quarterly thereafter. DNS/Designee to monitor.	

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	stools. foul smelling and mucousy. will cont to monitor" During interview of the Social Services Designee (SSD) on 6/10/11 at 1:45 p.m., the SSD indicated Resident #33 had resided with Resident #34 since 7/7/10. A facility policy titled "Clostridium Difficile", dated 12/28/10, was received from the Administrator on 6/10/11 at 11:55 a.m. The policy indicated under "E. Resident Placement: 2. Cohort the individual with someone who does not have indwelling tubes, catheters, or open wounds." 3.1-18(b)(2)			